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SENATE BILL 228

**48TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2008**

INTRODUCED BY

Steve Komadina

AN ACT

RELATING TO HEALTH INSURANCE; ENACTING THE HEALTH INSURANCE  
EXCHANGE ACT; PROVIDING FOR POWERS AND DUTIES; PROVIDING FOR  
PARTICIPATING EMPLOYER PLANS AND PARTICIPATING INSURANCE PLANS;  
PROVIDING FOR ELIGIBILITY AND BENEFITS; PROVIDING FOR STATE  
RESIDENT PARTICIPATION; REQUIRING NEW MEXICO RESIDENTS TO SHOW  
PROOF OF HEALTH COVERAGE; REPEALING THE HEALTH INSURANCE  
ALLIANCE ACT.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. [NEW MATERIAL] SHORT TITLE.--Sections 1  
through 15 of this act may be cited as the "Health Insurance  
Exchange Act".

Section 2. [NEW MATERIAL] DEFINITIONS.--As used in the  
Health Insurance Exchange Act:

A. "applicant" means an individual seeking to

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1 participate in the exchange;

2 B. "board" means the board of directors of the  
3 exchange;

4 C. "carrier" means a person or organization subject  
5 to the authority of the superintendent or the provisions of the  
6 New Mexico Insurance Code that provides one or more health  
7 benefit or insurance plans in the state;

8 D. "creditable coverage" means continual coverage  
9 of the applicant under any of the following health plans, not  
10 including excepted benefits, with no lapse in coverage of more  
11 than sixty-three days immediately prior to the date of  
12 application for coverage through the exchange:

- 13 (1) a group health plan;
- 14 (2) health insurance coverage;
- 15 (3) Part A or Part B of Title 18 of the Social  
16 Security Act;
- 17 (4) Title 19 or Title 21 of the Social  
18 Security Act;
- 19 (5) tricare, pursuant to Chapter 55 of Title  
20 10, United States Code;
- 21 (6) the Medical Insurance Pool Act;
- 22 (7) the federal employees health benefits  
23 program pursuant to Chapter 89 of Title 5, United States Code;
- 24 (8) health coverage pursuant to Section 5(e)  
25 of the federal Peace Corps Act;

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1 (9) a public health plan as defined by federal  
2 or state law or rule; or

3 (10) other qualifying coverage required by the  
4 federal Health Insurance Portability and Accountability Act of  
5 1996;

6 E. "dependent" means the spouse of the principal  
7 insured or an individual that is related to the principal  
8 insured by birth, marriage or adoption and that meets the  
9 definition of a dependent pursuant to the federal Internal  
10 Revenue Code of 1986;

11 F. "eligible individual" means an individual that  
12 may participate in the exchange by reason of meeting one or  
13 more of the following qualifications:

14 (1) the individual is a resident of New  
15 Mexico where the individual is and continues to be legally  
16 domiciled and physically residing on a full-time basis in a  
17 place of habitation in the state that remains the individual's  
18 principal residence and from which the individual is absent  
19 only for a temporary or transitory purpose;

20 (2) the individual is a dependent and a  
21 full-time student attending an institution outside of New  
22 Mexico but prior to attending the educational institution met  
23 the requirements of Paragraph (1) of this subsection;

24 (3) the individual is not a resident of New  
25 Mexico but is employed, at least twenty hours per week on a

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1 regular basis, at a location within the boundaries of the state  
2 by a bona fide employer, and the individual's employer does not  
3 offer health coverage or the individual is not eligible to  
4 participate in any health coverage plan offered by the  
5 individual's employer;

6 (4) the individual, whether a resident of New  
7 Mexico or not, is enrolled in, or eligible to enroll in, a  
8 participating employer plan;

9 (5) the individual is self-employed in New  
10 Mexico and if the individual is a nonresident self-employed  
11 individual, the individual's principal place of business is in  
12 New Mexico;

13 (6) the individual is a full-time student  
14 attending an institution of higher education located in New  
15 Mexico; or

16 (7) the individual, whether a resident of New  
17 Mexico or not, is a dependent of another individual who is an  
18 eligible individual;

19 G. "employer" means a person that employs at least  
20 one and no more than fifty individuals and files payroll tax  
21 information on its employees;

22 H. "excepted benefits" means:

23 (1) benefits not subject to requirements,  
24 including:

25 (a) coverage only for accident or

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- 1 disability income insurance;
- 2 (b) coverage issued as a supplement to
- 3 liability insurance;
- 4 (c) liability insurance, including
- 5 general liability insurance and automobile liability insurance;
- 6 (d) workers' compensation or similar
- 7 insurance;
- 8 (e) medical expense and loss of income
- 9 benefits;
- 10 (f) credit-only insurance;
- 11 (g) coverage for on-site medical
- 12 clinics; or
- 13 (h) other similar insurance coverage
- 14 under which benefits for medical care are secondary or
- 15 incidental to other insurance benefits;
- 16 (2) benefits not subject to requirements if
- 17 offered separately, including:
- 18 (a) limited scope dental or vision
- 19 benefits;
- 20 (b) benefits for long-term care, nursing
- 21 home care, home health care or community-based care; or
- 22 (c) other similar, limited benefits;
- 23 (3) benefits not subject to requirements if
- 24 offered as independent, noncoordinated benefits, including:
- 25 (a) coverage only for a specified

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1 disease or illness; and

2 (b) hospital indemnity or other fixed  
3 indemnity insurance; and

4 (4) benefits not subject to requirements if  
5 offered as a separate insurance policy, including:

6 (a) medicare supplemental health  
7 insurance;

8 (b) coverage supplemental to the  
9 coverage provided under Chapter 55 of Title 10, United States  
10 Code; or

11 (c) similar supplemental coverage  
12 provided for coverage under a group plan;

13 I. "exchange" means the health insurance exchange  
14 for participating employer plans and participating insurance  
15 plans created pursuant to the Health Insurance Exchange Act;

16 J. "participating employer plan" means a group  
17 health plan, as defined in the federal Employee Retirement  
18 Income Security Act of 1974, that is sponsored by an employer  
19 and for which the plan sponsor has entered into an agreement  
20 with the exchange for the exchange to offer and administer  
21 health coverage benefits for enrollees in the plan;

22 K. "participating individual" means an individual  
23 who has been determined by the exchange to be, and continues to  
24 remain, an eligible individual for purposes of obtaining  
25 coverage under participating insurance plans offered through

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1 the exchange;

2 L. "participating insurance plan" means a health  
3 benefit plan offered through the exchange;

4 M. "plan year" means the period of time during  
5 which the insured is covered under a health benefit plan  
6 pursuant to the contract governing the plan;

7 N. "preexisting condition provision" means a  
8 provision in a health benefit plan that limits, denies or  
9 excludes benefits for a period of time for an enrollee for  
10 expenses or services related to a medical condition that was  
11 present before the date the coverage commenced, whether or not  
12 any medical advice, diagnosis, care or treatment was  
13 recommended or received before that date; provided that the  
14 time period for a preexisting condition provision begins when  
15 application for insurance is made; and provided further that  
16 genetic information shall not be treated as a preexisting  
17 condition in the absence of a diagnosis of the condition  
18 related to such information;

19 O. "producer" means a person required to be  
20 licensed in the state to sell, solicit or negotiate insurance;

21 P. "qualifying event" means an event where an  
22 individual or dependent loses coverage or becomes eligible for  
23 coverage due to circumstances that include marriage, divorce,  
24 death of a spouse, adoption, change in employment or other  
25 similar event;

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1 Q. "rate" means the premium or fee charged by a  
2 health benefit plan for coverage under a plan; and

3 R. "superintendent" means the superintendent of  
4 insurance of the insurance division of the public regulation  
5 commission.

6 Section 3. [NEW MATERIAL] ESTABLISHMENT--PURPOSE AND  
7 CORPORATE FORM.--

8 A. The "health insurance exchange" is created as a  
9 nonprofit public corporation, separate and apart from the  
10 state, to provide increased access for health insurance in the  
11 state.

12 B. The exchange is created to provide the residents  
13 of the state and other individuals that may be eligible to  
14 participate with greater access to and choice and portability  
15 of health insurance products.

16 Section 4. [NEW MATERIAL] BOARD OF DIRECTORS.--

17 A. The exchange shall be governed by a board of  
18 directors. The board is a governmental entity for purposes of  
19 the Tort Claims Act, but neither the board nor the exchange  
20 shall be considered a governmental entity for any other  
21 purpose.

22 B. Each member shall be entitled to one vote in  
23 person or by proxy at each meeting.

24 C. The exchange shall operate subject to the  
25 supervision and approval of the board. The board shall consist

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1 of thirteen members that represent the geographic and ethnic  
2 diversity of the state as follows:

3 (1) two directors, elected by the carriers  
4 that participate in the exchange, who shall be officers or  
5 employees of those carriers;

6 (2) four directors, appointed by the governor,  
7 who shall be officers, general partners or proprietors of  
8 employers that participate in the exchange, as follows:

9 (a) one director that represents  
10 nonprofit corporations;

11 (b) one director that represents  
12 employers with fifty or fewer employees; and

13 (c) two directors that are nominated by  
14 the New Mexico legislative council;

15 (3) two directors, appointed by the governor,  
16 who shall be employees of employers that participate in the  
17 exchange;

18 (4) one director that is a physician licensed  
19 by the state and is elected by the New Mexico medical society;

20 (5) one director that represents and is  
21 elected by the New Mexico hospital association;

22 (6) one director that is elected by the New  
23 Mexico association of health underwriters;

24 (7) one director that represents the Indian  
25 nations, tribes and pueblos of the state; and

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1 (8) the superintendent or the superintendent's  
2 designee, who shall be a nonvoting member.

3 D. A majority of the thirteen board members shall  
4 constitute a quorum. The board may allow members'  
5 participation in meetings by telephone or other electronic  
6 medium that allows full participation. The board shall elect a  
7 chair and vice chair of the board once each even-numbered year.

8 E. The directors shall be elected for initial terms  
9 of three years or less, staggered so that the term of at least  
10 one director expires on June 30 of each year. The directors  
11 appointed by the governor shall be appointed for initial terms  
12 of three years or less, staggered so that the term of at least  
13 one director expires on June 30 of each year. Following the  
14 initial terms, directors shall be elected or appointed for  
15 terms of three years. A director whose term has expired shall  
16 continue to serve until a successor is elected or appointed.

17 F. Whenever a vacancy on the board occurs, the  
18 electing or appointing authority of the position that is vacant  
19 shall fill the vacancy by electing or appointing an individual  
20 to serve the balance of the unexpired term; provided that when  
21 a vacancy occurs in one of the director's positions elected by  
22 the members, the superintendent is authorized to appoint a  
23 temporary replacement director until the next scheduled  
24 election of directors elected by the members is held. The  
25 individual elected or appointed to fill a vacancy shall meet

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1 the requirements for initial election or appointment to that  
2 position.

3 G. Directors may be reimbursed by the board as  
4 provided in the Per Diem and Mileage Act for nonsalaried public  
5 officers, but shall receive no other compensation, perquisite  
6 or allowance from the board.

7 H. The board shall appoint an executive director of  
8 the exchange, who shall:

9 (1) be a full-time employee of the exchange;

10 (2) administer all of the exchange's  
11 activities and contracts;

12 (3) supervise staff of the exchange; and

13 (4) serve at the pleasure of the board.

14 I. The board shall set the salary of the executive  
15 director and staff of the exchange.

16 Section 5. [NEW MATERIAL] HEALTH INSURANCE EXCHANGE--  
17 DUTIES.--The exchange shall:

18 A. publicize the existence of the exchange and  
19 disseminate information on its eligibility requirements and  
20 enrollment procedures;

21 B. establish and administer procedures for  
22 enrolling eligible individuals in the exchange, including:

23 (1) creating a standard application form to  
24 collect information necessary to determine the eligibility and  
25 previous coverage history of an applicant; and

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1 (2) preparing and distributing certificate of  
2 eligibility forms and application forms to insurance producers  
3 and the general public;

4 C. establish and administer procedures for the  
5 election of coverage by participating individuals during and  
6 outside of open enrollment periods upon the occurrence of any  
7 qualifying event, including preparing and distributing to  
8 participating individuals:

9 (1) descriptions of the coverage, benefits,  
10 limitations, premiums and cost-sharing for all participating  
11 insurance plans; and

12 (2) forms and instructions for electing  
13 coverage and arranging payment for coverage;

14 D. collect and transmit to the applicable  
15 participating plans all premium payments or contributions made  
16 by or on behalf of participating individuals, including  
17 developing mechanisms to:

18 (1) receive and process automatic payroll  
19 deductions for participating individuals enrolled in  
20 participating employer plans;

21 (2) enable participating individuals to pay,  
22 in whole or in part, for coverage through the exchange by  
23 electing to assign to the exchange any state income tax credits  
24 or deductions or federal earned income tax credit payments due  
25 to the participating individual; and

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1 (3) receive and process any financial  
2 reimbursement received from or through federal or state funding  
3 or premium assistance support payments for health insurance, as  
4 may be provided by law;

5 E. upon request, issue certificates of previous  
6 coverage in accordance with the provisions of the federal  
7 Health Insurance Portability and Accountability Act of 1996 to  
8 all individuals who cease to be covered by a participating  
9 insurance plan;

10 F. establish procedures to account for all funds  
11 received and disbursed by the exchange, including:

12 (1) maintaining a separate, segregated  
13 management account for the receipt and disbursement of money  
14 allocated to fund for the administration of the exchange; and

15 (2) maintaining a separate, segregated  
16 operations account for:

17 (a) the receipt of all premium payments  
18 or contributions made by or on behalf of participating  
19 individuals; and

20 (b) the distribution of premium payments  
21 to participating insurance plans and of commissions or payments  
22 to producers and other organizations that are allowed pursuant  
23 to Section 13 of the Health Insurance Exchange Act to receive  
24 payments for their services in enrolling eligible individuals  
25 or groups in the exchange;

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1 G. submit to the superintendent, following the end  
2 of each plan year, the report of an independent audit of the  
3 exchange's accounts for the plan year;

4 H. operate in accordance with all requirements and  
5 restrictions set forth in the Health Insurance Exchange Act,  
6 the New Mexico Insurance Code and other applicable state and  
7 federal laws; and

8 I. provide a report by July 1, 2010 to the  
9 governor, the legislature and the superintendent on the  
10 feasibility of expanding the exchange to employers with more  
11 than fifty employees.

12 Section 6. [NEW MATERIAL] HEALTH INSURANCE EXCHANGE--  
13 POWERS.--The exchange may:

14 A. contract with vendors to perform one or more of  
15 the functions specified in Section 5 of the Health Insurance  
16 Exchange Act;

17 B. contract with private or public social service  
18 agencies to administer application, eligibility verification,  
19 enrollment and premium payments for specified groups or  
20 populations of eligible individuals or participating  
21 individuals;

22 C. contract with an employer to act as the plan  
23 administrator for participating employer plans to undertake the  
24 obligations required by the federal Employee Retirement Income  
25 Security Act of 1974 of a plan administrator;

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1           D. assess each participating insurance plan for the  
2 administration and operating expenses of the exchange in the  
3 previous calendar year an amount that achieves equity of  
4 adjustments among participating insurance plans; provided,  
5 however, that a plan may take a fifty percent credit on the  
6 plan's premium tax;

7           E. seek and directly receive grant funding from  
8 federal or state agencies or political subdivisions or private  
9 philanthropic organizations to defray the costs of operating  
10 the exchange;

11           F. establish and administer operating procedures  
12 governing the operations of the exchange, including an annual  
13 equitable and proportional assessment of all its participating  
14 insurance plans for the net administrative expenses that  
15 occurred in the previous calendar year, taking into account  
16 investment income for the period and other appropriate gains  
17 and losses;

18           G. establish one or more service centers within the  
19 state to facilitate enrollment;

20           H. sue and be sued or otherwise take any necessary  
21 or proper legal action;

22           I. establish bank accounts; and

23           J. enroll all eligible individuals through the  
24 exchange, subject to the provisions of the Health Insurance  
25 Exchange Act.

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1           Section 7.   ~~[NEW MATERIAL]~~ ENROLLMENT AND COVERAGE

2 ELECTION.--

3           A. Any individual may apply to participate in the  
4 exchange. Any public or private employer may apply on behalf  
5 of those individuals that may be eligible. Upon determination  
6 by the exchange that an individual is eligible to participate  
7 in the exchange, the individual may enroll or, if applicable,  
8 be enrolled by the individual's parent or legal guardian, in a  
9 participating insurance plan offered through the exchange  
10 during the next open enrollment period or when otherwise  
11 provided by the Health Insurance Exchange Act.

12           B. The exchange shall verify the eligibility of all  
13 applicants for private coverage. The state shall verify the  
14 eligibility of all applicants for state-sponsored or state-  
15 subsidized coverage, unless the state enters into an agreement  
16 with the exchange whereby the state reimburses the exchange for  
17 public program eligibility verification. The exchange may  
18 require that applicants submit appropriate documentation as  
19 considered necessary to verify the applicant's eligibility.

20           C. From November 1 to November 30 of each year, the  
21 exchange shall administer an open enrollment during which any  
22 eligible individual may enroll for coverage effective January 1  
23 of the following calendar year in any participating insurance  
24 plan offered through the exchange without a waiting period and  
25 shall not be declined coverage.

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1           D. The first ninety days after the exchange begins  
2 to accept applications shall be considered the initial open  
3 season.

4           E. An eligible individual may enroll in a  
5 participating insurance plan offered through the exchange  
6 without a waiting period and shall not be declined coverage, at  
7 a time other than the annual open enrollment; provided that the  
8 individual does so within sixty-three days of one of the  
9 following qualifying events:

10                   (1) the individual loses coverage in an  
11 existing health insurance plan due to the death of a spouse,  
12 parent or legal guardian;

13                   (2) the individual or a covered dependent  
14 loses coverage in an existing health insurance plan due to a  
15 change in the individual's employment status;

16                   (3) the individual or a covered dependent  
17 loses coverage in an existing health insurance plan because of  
18 a divorce, separation or other change in familial status;

19                   (4) the individual loses coverage in an  
20 existing health insurance plan because the individual reaches  
21 an age at which coverage lapses under that plan;

22                   (5) the individual or a covered dependent  
23 becomes newly eligible by becoming a resident of the state or  
24 because the individual's place of employment has been changed  
25 to the state;

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1 (6) the individual becomes newly eligible by  
2 becoming the spouse or dependent of an eligible individual by  
3 reason of birth, adoption, court order or a change in custody  
4 arrangement;

5 (7) the individual becomes subject to a court  
6 order requiring the individual to provide health insurance  
7 coverage to certain dependents, or enters into a new  
8 arrangement for the custody of dependents that requires the  
9 providing of health insurance for those dependents; or

10 (8) the individual loses coverage in a plan  
11 offered through the exchange by reason of the employer plan  
12 terminating participation in the exchange prior to the end of  
13 the plan year.

14 Section 8. [NEW MATERIAL] PARTICIPATION OF PLANS IN THE  
15 EXCHANGE.--

16 A. No health benefit plan may be offered through  
17 the exchange unless the superintendent has first certified to  
18 the exchange that:

19 (1) the carrier seeking to offer the plan is  
20 licensed to issue health insurance or provide health coverage  
21 in the state and is in good standing with the insurance  
22 division of the public regulation commission; and

23 (2) the plan meets the requirements of this  
24 section and the employer plan and the carrier are in compliance  
25 with all other applicable state health insurance laws.

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1           B. No plan shall be certified that excludes from  
2 coverage any individual otherwise determined by the exchange to  
3 be eligible.

4           C. The certification of plans to be offered through  
5 the exchange shall not be subject to any state law requiring  
6 competitive bidding; provided, however, that this does not  
7 apply to participating insurance plans offered pursuant to the  
8 Health Care Purchasing Act.

9           D. Each certification shall be valid for at least  
10 one year and may be made automatically renewable from year to  
11 year in the absence of notice of either:

12                   (1) withdrawal by the superintendent; or

13                   (2) discontinuation of participation in the  
14 exchange by the plan or carrier.

15           E. Certification of a plan may be withheld only  
16 after notice to the carrier and an opportunity for a hearing.  
17 The superintendent may decline to renew the certification of  
18 any carrier at the end of a certification term.

19           F. Each plan certified by the superintendent as  
20 eligible to be offered through the exchange shall contain a  
21 detailed description of benefits offered and patient cost-  
22 sharing amounts, including maximums, limitations, exclusions,  
23 benefit limits and other plan characteristics deemed necessary  
24 by the board for participants to make informed coverage  
25 selections.

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1           G. Each plan certified by the superintendent as  
2 eligible to be offered through the exchange shall provide,  
3 subject to the plan's patient cost-sharing amounts, major  
4 medical coverage that includes the following:

- 5                   (1) hospital benefits;
- 6                   (2) surgical benefits;
- 7                   (3) in-hospital medical benefits;
- 8                   (4) ambulatory patient benefits;
- 9                   (5) prescription drug benefits; and
- 10                  (6) mental health benefits.

11           H. Carriers shall offer participating insurance  
12 plans through the exchange at rates developed pursuant to  
13 Section 59A-18-13.1 NMSA 1978.

14           I. The rates determined for the first plan year for  
15 which the participating insurance plan is offered through the  
16 exchange may be adjusted by the carrier for subsequent plan  
17 years based on experience and any later modifications to plan  
18 benefits; provided, however, that any adjustments in rates  
19 shall be made in advance of the plan year for which they will  
20 apply and on a basis that, in the judgment of the  
21 superintendent, is consistent with the general practice of  
22 carriers that issue health benefit plans to large employers and  
23 in compliance with the New Mexico Insurance Code.

24           J. The exchange shall not decline, refuse to offer  
25 or otherwise restrict the offering to any participating

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1 individual of any participating insurance plan that has  
2 obtained in a timely fashion in advance of the annual open  
3 enrollment certification by the superintendent in accordance  
4 with the provisions of this section.

5 K. The exchange shall not impose on any  
6 participating insurance plan or on any carrier or plan seeking  
7 to participate in the exchange any terms or conditions,  
8 including any requirements or agreements with respect to rates  
9 or benefits, beyond or in addition to those terms and  
10 conditions established and imposed by the superintendent in  
11 certifying plans under the provisions of this section;  
12 provided, however, that nothing in this subsection shall be  
13 construed to prohibit the exchange from encouraging carriers to  
14 adopt standardized policy terms, benchmark benefit packages and  
15 similar cost-sharing requirements to facilitate comparison by  
16 participants.

17 L. The superintendent shall establish and  
18 administer regulations and procedures for certifying plans to  
19 participate in the exchange.

20 Section 9. [NEW MATERIAL] UNDERWRITING RULES.--The  
21 following rules shall govern the imposition by carriers of a  
22 preexisting condition provision and rate surcharges with  
23 respect to any participating individual covered by any  
24 participating insurance plan:

25 A. except as otherwise specified in Subsection C of

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1 this section, during any open enrollment a participating  
2 individual who elects to choose a different participating  
3 insurance plan or plan option for the next plan year shall not  
4 be subject to a preexisting condition provision and shall be  
5 charged the standard rate of the new participating insurance  
6 plan or plan option developed pursuant to Section 59A-18-13.1  
7 NMSA 1978. The provisions of this subsection shall also apply  
8 to any election by a participating individual of coverage for  
9 any dependent who is also a participating individual;

10 B. a new participating individual with eighteen  
11 months or more of creditable coverage who enrolls in a  
12 participating insurance plan shall not be subject to a  
13 preexisting condition provision and shall be charged the  
14 standard rate for the participating insurance plan developed  
15 pursuant to Section 59A-18-13.1 NMSA 1978;

16 C. a new participating individual with creditable  
17 coverage of less than eighteen months may enroll in a  
18 participating insurance plan, but the participating individual  
19 may be subject to a preexisting condition provision for a  
20 period not to exceed twelve months or charged a premium not to  
21 exceed an amount pursuant to Section 59A-18-13.1 NMSA 1978;  
22 provided that any rate surcharge shall not be applied on or  
23 after the third year of the individual's enrollment in any  
24 participating insurance plan;

25 D. in cases where an individual is enrolled in a

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1 participating insurance plan as a newly eligible dependent of a  
2 participating individual by reason of birth, adoption, court  
3 order or a change in custody arrangement, either during open  
4 season or outside of open season, a carrier shall not impose a  
5 preexisting condition provision or any change in the rate  
6 charged to the participating individual, except for a  
7 difference in the participating insurance plan's standard rates  
8 that reflect the addition of a new dependent to the  
9 participating individual's coverage;

10 E. periods of creditable coverage with respect to  
11 an individual shall be established through presentation of  
12 certifications or in such other manner as may be specified in  
13 state or federal law;

14 F. for new participating individuals without  
15 creditable coverage, or with only limited creditable coverage  
16 as defined in Subsection C of this section, a carrier may elect  
17 to waive the imposition of a preexisting condition provision  
18 and instead extend the applicable rate surcharge for an  
19 additional year beyond the time provided for in those  
20 subsections;

21 G. for purposes of this section, any individual who  
22 is a participating individual by reason of enrollment in a  
23 participating employer plan shall be deemed to have eighteen  
24 months of creditable coverage;

25 H. for purposes of this section, any federal health

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1 coverage tax credit eligible individual shall be deemed to have  
2 eighteen months of creditable coverage; and

3 I. a participating individual may continue or renew  
4 an individual policy in existence on July 1, 2008 that has a  
5 permanent exclusion of payment for preexisting conditions.

6 Section 10. [NEW MATERIAL] CONTINUATION OF COVERAGE.--

7 A. Any participating individual may continue to  
8 participate in any participating insurance plan as long as the  
9 individual remains an eligible individual, subject to the  
10 carrier's rules regarding cancellation for nonpayment of  
11 premiums or fraud, and shall not be canceled or nonrenewed  
12 because of any change in employer or employment status, marital  
13 status, health status, age, membership in any organization or  
14 other change that does not affect eligibility as defined in the  
15 Health Insurance Exchange Act.

16 B. A participating individual who is not a resident  
17 of the state and who ceases to be an eligible individual due to  
18 a qualifying event shall be deemed to remain an eligible  
19 individual and shall be deemed to remain a participating  
20 individual for a period not to exceed thirty-six months from  
21 the date of the qualifying event, if:

22 (1) the qualifying event consists of a loss of  
23 eligible individual status due to:

24 (a) voluntary or involuntary termination  
25 of employment for reasons other than gross misconduct; or

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1 (b) loss of qualified dependent status  
2 for any reason; and

3 (2) the participating individual elects to  
4 remain a participating individual and notifies the exchange of  
5 such election within sixty-three days of the qualifying event.

6 Section 11. [NEW MATERIAL] DISPUTE RESOLUTION.--

7 A. The superintendent shall establish procedures  
8 for resolving disputes arising from the operation of the  
9 exchange in accordance with the provisions of the Health  
10 Insurance Exchange Act, including disputes with respect to:

11 (1) the eligibility of an individual to  
12 participate in the exchange;

13 (2) the imposition of a coverage surcharge on  
14 a participating individual by a participating insurance plan;  
15 and

16 (3) the imposition of a preexisting condition  
17 provision on a participating individual by a participating  
18 insurance plan.

19 B. In cases where a carrier imposes a preexisting  
20 condition provision or a premium surcharge in connection with  
21 enrollment of a participating individual in a participating  
22 insurance plan offered by the carrier, and the participating  
23 individual disputes the imposition of such a provision or  
24 surcharge, the participating individual may request that the  
25 superintendent issue a determination as to the validity or

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1 extent of such provision or surcharge pursuant to the Health  
2 Insurance Exchange Act. The superintendent shall issue a  
3 determination within thirty days of the request being filed  
4 with the insurance division of the public regulation  
5 commission. If either the participating individual or the  
6 carrier disagrees with the outcome, a request for a hearing may  
7 be made pursuant to Chapter 59A, Article 4 NMSA 1978.

8 Section 12. [NEW MATERIAL] PARTICIPATING EMPLOYER  
9 PLANS.--

10 A. Any employer may apply to the exchange to be the  
11 sponsor of a participating employer plan.

12 B. Any employer seeking to be the sponsor of a  
13 participating employer plan shall, as a condition of  
14 participation in the exchange, enter into a binding agreement  
15 with the exchange, which shall include the following  
16 conditions:

17 (1) the sponsoring employer designates the  
18 exchange to be the plan's administrator for the employer's  
19 group health plan, and the exchange agrees to undertake the  
20 obligations required of a plan administrator under federal law;

21 (2) only the coverage and benefits offered by  
22 participating insurance plans shall constitute the coverage and  
23 benefits of the participating employer plan;

24 (3) any individuals eligible to participate in  
25 the exchange by reason of their eligibility for coverage under

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1 the employer's participating employer plan, regardless of  
2 whether any such individuals would otherwise qualify as  
3 eligible individuals if not enrolled in the participating  
4 employer plan, may elect coverage under any participating  
5 insurance plan and neither the employer nor the exchange shall  
6 limit the individual's choice of coverage from among all the  
7 participating insurance plans;

8 (4) the employer reserves the right to offer  
9 benefits supplemental to the benefits offered through the  
10 exchange, but any supplemental benefits offered by the employer  
11 shall constitute a separate plan or plans under federal law,  
12 for which the exchange may be the plan administrator;

13 (5) the employer agrees that, for the term of  
14 the agreement, the employer shall not offer to individuals  
15 eligible to participate in the exchange by reason of their  
16 eligibility for coverage under the employer's participating  
17 employer plan any separate or competing group health plan  
18 offering the same or substantially similar benefits as those  
19 provided by participating insurance plans through the exchange,  
20 regardless of whether any such individuals would otherwise  
21 qualify as eligible individuals if not enrolled in the  
22 participating employer plan;

23 (6) the employer reserves the right to  
24 determine the criteria for eligibility, enrollment and  
25 participation in the participating employer plan and the terms

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1 and amounts of the employer's contributions to that plan;  
2 provided that for the term of the agreement with the exchange,  
3 the employer agrees not to alter or amend any criteria or  
4 contribution amounts at any time other than during an annual  
5 period designated by the exchange for participating employer  
6 plans to make such changes in conjunction with the exchange's  
7 annual open season;

8 (7) the employer agrees to make available to  
9 the exchange any of the employer's documents, records or  
10 information, including copies of the employer's federal and  
11 state tax and wage reports that the superintendent reasonably  
12 determines are necessary for the exchange to verify:

13 (a) that the employer is in compliance  
14 with the terms of its agreement with the exchange governing the  
15 employer's sponsorship of a participating employer plan;

16 (b) that the participating employer plan  
17 is in compliance with applicable laws relating to employee  
18 welfare benefit plans; and

19 (c) the eligibility under the terms of  
20 the employer's plan of those individuals enrolled in the  
21 participating employer plan; and

22 (8) the employer agrees also to sponsor a  
23 "cafeteria plan" as permitted pursuant to 26 USCA Section 125  
24 for all employees eligible for coverage under the employer's  
25 participating employer plan.

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1 C. The exchange shall not enter into an agreement  
2 with an employer with respect to a participating employer plan  
3 if the agreement does not, at a minimum, incorporate the  
4 conditions specified in Subsection B of this section.

5 D. The exchange shall not enter into an agreement  
6 with an employer with respect to a participating employer plan  
7 for the exchange to provide the participating employer plan  
8 with any additional or different services or benefits not  
9 otherwise provided or offered to all other participating  
10 employer plans.

11 Section 13. [NEW MATERIAL] PRODUCERS.--

12 A. In cases when a producer licensed in the state  
13 enrolls in the exchange an eligible individual or group, the  
14 plan chosen by each individual or group shall pay the producer  
15 a commission as previously agreed upon and approved by the  
16 superintendent.

17 B. In cases when a member organization enrolls in  
18 the exchange its eligible members or the eligible members of  
19 its member entities, the plan chosen by each member  
20 organization shall pay the organization a fee equal to a  
21 commission as previously agreed upon and approved by the  
22 superintendent. Nothing in this section shall be deemed either  
23 to require a membership organization that enrolls persons in  
24 the exchange to be licensed by the state as a producer or to  
25 permit such an organization to provide any other services

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1 requiring licensure as a producer without first obtaining the  
2 license.

3 C. In cases when an individual or family is  
4 referred to or enrolled in a publicly financed or publicly  
5 subsidized plan through the exchange, an administrative  
6 enrollment and service fee may be charged in an amount not to  
7 exceed five dollars (\$5.00) per month per family or individual,  
8 whichever is less. Producers that participate in training  
9 about state-sponsored or state-funded creditable coverage that  
10 are certified by the exchange as having participated in such  
11 training shall not be liable for any action associated with  
12 offering those products so long as they are acting in good  
13 faith and in accordance with the training they received.

14 Section 14. [NEW MATERIAL] INSURANCE MARKET  
15 CONSOLIDATION.--

16 A. A carrier shall not issue or renew an individual  
17 health benefit plan, other than through the exchange, after the  
18 first day of the plan year following the first regular open  
19 season conducted by the exchange.

20 B. A carrier shall not issue or renew a group  
21 health benefit plan to an employer with fewer than fifty  
22 employees, other than through the exchange, after the first day  
23 of the plan year following the first regular open season  
24 conducted by the exchange.

25 C. Subsections A and B of this section shall not

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1 apply to any health benefit plan that consists solely of one or  
2 more excepted benefits.

3 Section 15. [NEW MATERIAL] PERSONAL RESPONSIBILITY.--

4 A. Effective July 1, 2010, a resident of New Mexico  
5 who is over the age of eighteen and under the age of sixty-five  
6 shall obtain coverage or offer proof of the resident's ability  
7 to pay for medical care for the resident and the resident's  
8 dependents.

9 B. An individual subject to the requirement in  
10 Subsection A of this section shall be deemed to be in  
11 compliance if the individual:

12 (1) indicates coverage under any health  
13 benefit plan; or

14 (2) demonstrates proof of financial security  
15 in accordance with Subsection C of this section.

16 C. An individual electing to demonstrate proof of  
17 financial security to pay for medical expenditures shall  
18 provide to the department of finance and administration proof  
19 of a bond in an amount equal to ten times the average annual  
20 premium rate for individual coverage for that individual's  
21 rating factors or shall deposit with the department an amount  
22 equal to that average annual premium rate in an escrow account  
23 that shall bear interest at a rate determined by the  
24 department.

25 D. If an individual subject to the requirement in

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1 Subsection A of this section fails to comply with the  
2 requirement, the secretary of finance and administration shall:

3 (1) establish an escrow account in the name of  
4 the individual;

5 (2) retain and deposit in the account all  
6 funds that may be owed to the individual by the state,  
7 including any overpayment by the individual of taxes imposed by  
8 the state; or

9 (3) obtain an order for the attachment of  
10 wages of the individual to satisfy the requirements of this  
11 section.

12 E. With respect to any escrow account established  
13 pursuant to this section, either by reason of an individual  
14 making the election specified in Subsection C of this section  
15 or by reason of an individual being subject to Subsection D of  
16 this section, the amount deposited, retained or collected shall  
17 not exceed the amount determined pursuant to Subsection C of  
18 this section for any individual. Nothing in this section shall  
19 be construed to authorize the secretary of finance and  
20 administration to retain any amount for purposes that otherwise  
21 would be paid to a state agency.

22 F. Money held in escrow pursuant to this section  
23 shall be disbursed by the secretary of finance and  
24 administration only to pay for medical claims for health care  
25 services provided to the individual during the period when the

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1 individual was not in compliance with Subsection A of this  
2 section. The secretary of finance and administration shall  
3 close the account and remit the remaining funds to the  
4 individual within six months of receiving notification that the  
5 individual has:

6 (1) elected to comply with the requirement in  
7 Subsection A of this section by submitting proof of insurance  
8 coverage pursuant to Subsection B of this section; or

9 (2) is no longer subject to Subsection A of  
10 this section by reason of no longer being a resident of the  
11 state.

12 G. If the secretary of finance and administration  
13 determines that an individual for whom an account has been  
14 established has not been a resident of the state for a  
15 consecutive period of thirty-six months or more, the secretary  
16 shall close the account and remit the remaining funds to the  
17 individual. If the secretary cannot locate the individual  
18 within twelve months, the secretary shall dispose of the funds  
19 pursuant to the Uniform Unclaimed Property Act (1995).

20 H. Any judgment payable by an individual to a  
21 hospital, physician or other health care provider for charges  
22 incurred during a period when the individual failed to comply  
23 with Subsection A of this section shall include an order  
24 permitting the attachment of the wages of the individual to  
25 satisfy the judgment.

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1 I. An individual may file with the department of  
2 finance and administration:

3 (1) an affidavit or written affirmation from  
4 an officer of a recognized religious denomination that the  
5 individual or family are bona fide members of a denomination  
6 whose religious teaching requires reliance upon prayer or  
7 spiritual means alone for health care or other healing; or

8 (2) an affidavit or written affirmation from  
9 the individual that the individual's religious beliefs, held  
10 either individually or jointly with others, do not permit the  
11 use of health insurance for health care or other healing.

12 J. Upon filing and approval of the affidavit or  
13 affirmation, the individual or family is exempt from the legal  
14 requirement of financial responsibility for health care for a  
15 period not to exceed twelve months on the basis of any one  
16 affidavit or affirmation; provided, however, that the  
17 individual or family is still subject to the provisions of  
18 Subsection H of this section.

19 K. The secretary of finance and administration  
20 shall compile and provide to the secretary of human services a  
21 list of individuals without known coverage and who may be  
22 eligible for programs administered by the human services  
23 department.

24 Section 16. Section 13-7-4 NMSA 1978 (being Laws 1997,  
25 Chapter 74, Section 4) is amended to read:

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1 "13-7-4. MANDATORY CONSOLIDATED PURCHASING.--

2 A. The publicly funded health care agencies shall  
3 enter into a cooperative consolidated purchasing effort to  
4 provide plans of health care benefits for the benefit of  
5 eligible participants of the respective agencies. The request  
6 for [~~proposal~~] proposals shall set forth one or more plans of  
7 health care benefits and shall include accommodation of fully  
8 funded arrangements as well as varying degrees of self-funded  
9 pool options.

10 B. A consolidated purchasing request for proposals  
11 for all health care benefits by the publicly funded health care  
12 agencies shall be issued on or before July 1, 1999, and any  
13 contracts for health care benefits renewed or issued on or  
14 after July 1, 2000 shall be the result of consolidated  
15 purchasing.

16 C. All requests for proposals issued as part of the  
17 consolidated purchasing shall include at least one distinct  
18 service area consisting of the Albuquerque metropolitan area.  
19 Proposals on a distinct service area shall be evaluated  
20 separately.

21 D. The publicly funded health care agencies shall  
22 purchase health care coverage for their eligible participants  
23 through participating insurance plans in the health insurance  
24 exchange created pursuant to the Health Insurance Exchange  
25 Act."

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1           Section 17. A new section of the Public Assistance Act is  
2 enacted to read:

3           "[NEW MATERIAL] HEALTH COVERAGE--PUBLIC PROGRAMS--PURCHASE  
4 THROUGH THE HEALTH INSURANCE EXCHANGE.--The department shall  
5 contract with participating insurance plans through the health  
6 insurance exchange created pursuant to the Health Insurance  
7 Exchange Act to purchase health coverage for individuals  
8 eligible for programs that are funded in whole or in part by  
9 the state, including programs created by Title 19 or Title 21  
10 of the Social Security Act."

11           Section 18. A new section of the New Mexico Insurance  
12 Code is enacted to read:

13           "[NEW MATERIAL] COLLECTION AND USE OF ENROLLMENT DATA.--

14           A. The superintendent shall collect and compile  
15 enrollment information on a quarterly basis as follows:

16                       (1) a list from the health insurance exchange  
17 of individuals currently enrolled in a participating insurance  
18 plan through the exchange;

19                       (2) a list from the human services department  
20 of individuals currently enrolled in health coverage programs  
21 administered by the department; and

22                       (3) a list from health insurers of individuals  
23 currently enrolled in each benefit plan they provide through  
24 insurance or administrative services.

25           B. The superintendent shall communicate enrollment

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1 information to the secretary of finance and administration to  
2 ensure compliance with Section 15 of the Health Insurance  
3 Exchange Act.

4 C. The superintendent may communicate enrollment  
5 information to an agency or a state contractor solely for the  
6 purpose of establishing a statewide electronic eligibility  
7 verification system accessible by healthcare providers;  
8 provided, however, that patient information is protected  
9 pursuant to the federal Health Insurance Portability and  
10 Accountability Act of 1996."

11 Section 19. Section 59A-23C-5 NMSA 1978 (being Laws 1991,  
12 Chapter 153, Section 5, as amended) is amended to read:

13 "59A-23C-5. RESTRICTIONS RELATING TO PREMIUM RATES.--

14 A. Premium rates for health benefit plans subject  
15 to the Small Group Rate and Renewability Act shall be subject  
16 to the following provisions:

17 (1) the index rate for a rating period for any  
18 class of business shall not exceed the index rate for any other  
19 class of business by more than ~~[twenty percent]~~ the following  
20 percentages for policies issued or delivered in the respective  
21 year:

22 (a) twenty percent through December 31,  
23 2008;

24 (b) eighteen percent for calendar year  
25 2009;

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- 1                                    (c) sixteen percent for calendar year  
2     2010;  
3                                    (d) fourteen percent for calendar year  
4     2011;  
5                                    (e) thirteen percent for calendar year  
6     2012;  
7                                    (f) twelve percent for calendar year  
8     2013;  
9                                    (g) eleven percent for calendar year  
10    2014; and  
11                                    (h) ten percent for every year  
12    thereafter;

13                                    (2) for a class of business, the premium rates  
14    charged during a rating period to small employers with similar  
15    case characteristics for the same or similar coverage, or the  
16    rates that could be charged to those employers under the rating  
17    system for that class of business, shall not vary from the  
18    index rate by more than [~~twenty percent of the index rate~~] the  
19    following percentages of the index rate for policies issued or  
20    delivered in the respective year:

- 21                                    (a) twenty percent through December 31,  
22    2008;  
23                                    (b) eighteen percent for calendar year  
24    2009;  
25                                    (c) sixteen percent for calendar year

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1 2010;

2 (d) fourteen percent for calendar year

3 2011;

4 (e) thirteen percent for calendar year

5 2012;

6 (f) twelve percent for calendar year

7 2013;

8 (g) eleven percent for calendar year

9 2014; and

10 (h) ten percent for every year

11 thereafter;

12 (3) the percentage increase in the premium  
13 rate charged to a small employer for a new rating period may  
14 not exceed the sum of the following:

15 (a) the percentage change in the new  
16 business premium rate measured from the first day of the prior  
17 rating period to the first day of the new rating period. In  
18 the case of a class of business for which the small employer  
19 carrier is not issuing new policies, the carrier shall use the  
20 percentage change in the base premium rate;

21 (b) an adjustment, not to exceed ten  
22 percent annually and adjusted pro rata for rating periods of  
23 less than one year due to the claim experience, health status  
24 or duration of coverage of the employees or dependents of the  
25 small employer as determined from the carrier's rate manual for

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1 the class of business; and

2 (c) any adjustment due to change in  
3 coverage or change in the case characteristics of the small  
4 employer as determined from the carrier's rate manual for the  
5 class of business; and

6 (4) in the case of health benefit plans issued  
7 prior to the effective date of the Small Group Rate and  
8 Renewability Act, a premium rate for a rating period may exceed  
9 the ranges described in Paragraph (1) or (2) of this subsection  
10 for a period of five years following the effective date of the  
11 Small Group Rate and Renewability Act. In that case, the  
12 percentage increase in the premium rate charged to a small  
13 employer in that class of business for a new rating period may  
14 not exceed the sum of the following:

15 (a) the percentage change in the new  
16 business premium rate measured from the first day of the prior  
17 rating period to the first day of the new rating period. In  
18 the case of a class of business for which the small employer  
19 carrier is not issuing new policies, the carrier shall use the  
20 percentage change in the base premium rate; and

21 (b) any adjustment due to change in  
22 coverage or change in the case characteristics of the small  
23 employer as determined from the carrier's rate manual for the  
24 class of business.

25 B. Nothing in this section is intended to affect

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1 the use by a small employer carrier of legitimate rating  
2 factors other than claim experience, health status or duration  
3 of coverage in the determination of premium rates. Small  
4 employer carriers shall apply rating factors, including case  
5 characteristics, consistently with respect to all small  
6 employers in a class of business.

7 C. A small employer carrier shall not involuntarily  
8 transfer a small employer into or out of a class of business.  
9 A small employer carrier shall not offer to transfer a small  
10 employer into or out of a class of business unless the offer is  
11 made to transfer all small employers in the class of business  
12 without regard to case characteristics, claim experience,  
13 health status or duration since issue.

14 D. Prior to usage and June 14, 1991, each carrier  
15 shall file with the superintendent the rate manuals and any  
16 updates thereto for each class of business. A rate filing fee  
17 is payable under Subsection U of Section 59A-6-1 NMSA 1978 for  
18 the filing of each update. The superintendent shall disapprove  
19 within sixty days of receipt of a complete filing or the filing  
20 is deemed approved. If the superintendent disapproves the form  
21 during the sixty-day review period, ~~he~~ the superintendent  
22 shall give the carrier written notice of the disapproval  
23 stating the reasons for disapproval. At any time, the  
24 superintendent, after a hearing, may disapprove a form or  
25 withdraw a previous approval. The superintendent's order after

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1 the hearing shall state the grounds for disapproval or  
2 withdrawal of a previous approval and the date not less than  
3 twenty days later when disapproval or withdrawal becomes  
4 effective."

5 Section 20. TEMPORARY PROVISION--HEALTH INSURANCE  
6 ALLIANCE.--The board of directors of the health insurance  
7 exchange created pursuant to the Health Insurance Exchange Act  
8 shall meet with the board of directors of the New Mexico health  
9 insurance alliance by October 1, 2008 and at least quarterly  
10 through June 30, 2009 to:

11 A. provide portability of coverage for individuals  
12 covered through the New Mexico health insurance alliance to the  
13 extent possible through the health insurance exchange;

14 B. provide for the transition of other functions of  
15 the New Mexico health insurance alliance to the health  
16 insurance exchange as permitted by law or rule; and

17 C. prepare a report to the first session of the  
18 forty-ninth legislature on the transition of functions to the  
19 health insurance exchange and on any recommendations to the  
20 legislature for continued and expanded health coverage of the  
21 state's residents.

22 Section 21. REPEAL.--Sections 59A-56-1 through 59A-56-25  
23 NMSA 1978 (being Laws 1994, Chapter 75, Sections 1 through 25,  
24 as amended) are repealed effective July 1, 2009.

25 Section 22. EFFECTIVE DATE.--The effective date of the  
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1 provisions of this act is July 1, 2008.

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